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APPLICATION FORM

"Emergency On-Line Registry for People with Special Needs"

WAIVER AND GENERAL RELEASE OF CONFIDENTIAL INFORMATION

I/We expressly understand and agree that under P.L. 33-54, the Guam Fire Department (GFD) in collaboration with the Department of Integrated Services for Individuals with Disabilities (DISID) has been mandated to create an online registry for persons with special needs to assist first responders such as police, fire fighters, paramedics, or emergency medical technicians to interact appropriately and effectively respond in the event of an emergency such as an accident, natural disaster, or terrorist attack. My information or that of a parent or guardian, family member, or ward may be included in the registry only by completing the attached form and providing the information to DISID or GFD..

DISID, the GFD and its officers, agents, representatives, and employees are not responsible for determining whether providing information is suitable for my parent or guardian, family member, ward, or me; only I will make that decision. All information will be kept confidential and voluntarily provided and it is the applicant's responsibility to provide information that they feel is important to the Registry.

I, acknowledge that I am the authorized representative and can sign on behalf of an individual with special needs, a parent or guardian, family member, or ward as stated in a valid Power of Attorney or other such documents.

I also understand that police, fire, or other personnel will not supply a parent or guardian, family member, ward, or me with preferential consideration in an emergency because I completed and provided DISID and GFD the attached registration form.

I understand that by completing the attached registration form, I am providing health information to DISID and GFD. My signature below indicates the waiver of my right or the right of my parent or guardian, family member, or ward to the confidentiality of the information given to DISID and GFD.

I understand that DISID and GFD will keep the health information confidential and will use it only as permitted and necessary, which may include public health activities. I also understand that this waiver and general release of confidential information is valid for one year from the date of my signature below and I must update the information provided in the registry if it changes or as requested by DISID or GFD.

By signing below, I release and hold harmless on behalf of my parent or guardian, family member, ward, or myself, the Government of Guam, its agents, representatives, and employees from any liability or potential liability including but not limited to accidents, injuries, or death arising out of or related to the information I have provided on the attached form.

I have read this Waiver and General Release of Confidential Information and fully understand its terms and voluntarily accept them or accept them on behalf of my parent, family member, or ward.

I. PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____ Blood/RH Type: _____

Eye Color: _____Hair Color: _____ Birthmarks/Scars/Tattoos: _____

Date of Birth: _____ Place of Birth: _____ Marital Status: _____

Ethnicity/Race: _____ Languages Spoken *(Primary/Secondary):* _____

Home Address/Apt./Room#: _____

Name of Complex/Subdiv./Apt./Facility:_____ Is there an elevator?:_____

Mailing Address: _____

Email Address: _____ Veteran: ☐ Yes ☐ No

(Note: Email Address is mandatory. If you don't have an email address, a DISID Social Worker will be able to provide you with assistance in setting up an email account).

Telephone (Home): _____ (Cell): _____ (Work): _____

Healthcare Provider: _____ Member ID#: _____

Caregiver or Advocate: _____ Contact Number: _____

II. EMERGENCY CONTACT OR PARENT/GUARDIAN INFORMATION (If applicable):

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: ☐ Male ☐ Female Relationship _____ Email Address: _____

Home Address: _____

Mailing Address: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

III. SPECIAL NEEDS INFORMATION:

Type of Disability**:** ☐ Blind/Low Vision ☐ Mobility Impairment ☐ Seizure ☐ Mental Health Condition
☐ Memory Loss ☐ Speech Impairment ☐ Deaf/Hard of Hearing ☐ Developmental/Intellectual Disability

Do you need an American Sign Language (ASL) interpreter? ☐ Yes ☐ No
Please describe your communication methods and ways officers can best communicate with you:

_____

TTY: _____ VRS: _____ Text: _____

Assistive Devices: ☐ Wheelchair ☐ Scooter ☐ Walker ☐ Cane ☐ Crutches ☐ Prosthesis
☐ Walking Stick ☐ Hearing Aid(s) ☐ Pacemaker ☐ Other: _____ ☐ Service Animal: _____

Electricity Dependent: ☐ Ventilator ☐ Home Oxygen System ☐ Other: _____

Medical Needs: ☐ Medications ☐ Dialysis ☐ Feeding Tube ☐ Asthma Inhaler ☐ Other: _____

Transportation: ☐ I am self-ambulatory ☐ I am non-ambulatory and require stretcher transport
☐ Ambulatory with assistance ☐ I need a wheelchair-lift vehicle

Other requirements: _____

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name of Parent or Guardian	Signature of Parent or Guardian	Date